BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT C. TEAGUE, M.D.,** Holder of License No. **3925** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-09A-3925-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (License Revocation)

On October 7, 2009, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Brian Brendan Tully's proposed Findings of Fact and Conclusions of Law and Recommended Order. Robert Teague M.D., ("Respondent") appeared before the Board with legal counsel Nancy D. Petersen, Assistant Attorney General Anne Froedge, represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. Robert T. Teague, M.D. ("Respondent") is the holder of License No. 3925 issued by the Board.
3. On June 23, 2009, the Board issued Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License against Respondent's License No. 3925 in Case Nos. MD-08-1469A, MD-09-0522A, MD-09-0528A, and MD-09-0782. The Board ordered the summary suspension of Respondent's medical license to protect the public health, safety or welfare, subject to a formal hearing.

4. The Board issued a Complaint and Notice of Hearing in Docket No. 09A-3925-MDX covering Case Nos. MD-08-1469A, MD-09-0522A, MD-09-0528A, and MD-09-0782. The Complaint and Notice of Hearing advised Respondent and his counsel of record of the time, date, and location of the evidentiary hearing.

5. The Board forwarded Docket No. 09A-3925-MDX to the Office of Administrative Hearings, an independent agency, for formal hearing.

6. The commencement of the scheduled hearing on August 18, 2009, at 8:00 a.m. was delayed 15 minutes to allow for the late arrival of Respondent and his counsel of record. After the delay, the Administrative Law Judge commenced the hearing in Respondent's absence. At 8:25 a.m., Respondent and his counsel appeared at the hearing.

7. Respondent is a 79-year-old family practitioner. He graduated medical school in 1955.

Case No. MD-09-0522A

8. The Board initiated case after Respondent failed to submit a quarterly report from his psychiatrist pursuant to a non-disciplinary Stipulated Health Agreement ("SHA") in Case Number MD-07-0237A.

9. On July 18, 2008, Respondent executed the SHA and agreed to comply with its terms and conditions. Respondent agreed with the following acknowledgment, which preceded his signature: "**PHYSICIAN ACKNOWLEGES THAT PHYSICIAN HAS READ THIS SHA, UNDERSTANDS ITS TERMS, AND AGREES TO COMPLY.**" (Emphasis in the original.)

10. The Board approved the SHA on July 21, 2008.

11. The SHA required, among other things, that Respondent enter treatment with a Board-approved psychiatrist and submit quarterly reports to the Board beginning September 2008.

12. Respondent failed to submit his March 2009 quarterly report from his psychiatrist. Respondent admitted that he did not submit his quarterly report because he had discontinued treatment with his psychiatrist in violation of the SHA.

13. On May 7, 2009, Respondent executed a non-disciplinary Consent Agreement for Practice Limitation in Case No. MD-09-0522A. By executing the Consent Agreement for Practice Limitation, Respondent agreed to the following statement:

> 1. Physician has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Physician acknowledges that he understands he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

14. The Board executed the Consent Agreement for Practice Limitation on May 8, 2009.

15. The Consent Agreement for Practice Limitation contains the following Order, which Respondent consented to abide by:

ORDER

IT IS HEREBY ORDERED THAT:

1. Physician's practice is limited in that he shall not practice medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications until Physician applies to the Board and receives permission to do so. The Board may require any combination of staff approved assessments, evaluations, treatments, examinations or interviews it finds necessary to assist in determining whether Physician is able to safely resume such practice.

2. The Board retains jurisdiction and may initiate an action based on any violation of this Consent Agreement.

16. Respondent violated the terms of the Consent Agreement for Practice Limitation as described in the below Findings of Fact.

Case No. MD-09-0782A

17. The Board initiated Case No. MD-09-0782A after receiving a complaint from Costco Pharmacy in Glendale, Arizona.

18. The Costco Pharmacy complaint was dated June 5, 2009 from a pharmacy tech. A patient presented the pharmacist with a prescription for Oxycontin written by Respondent. The prescription was undated. The pharmacist contacted Respondent by telephone to authenticate the prescription. The pharmacist wrote that his encounter with Respondent was "less than professional" and "a bit strange." The pharmacist concluded the complaint with the following statement: "I

think, based on the information printed regarding previous prescribing, his history of probations, and DEA reprimands, and my conversation, that it warrants further investigation."

19. Costco Pharmacy submitted prescriptions written and signed by Respondent, including four written in June 2009 for the following: "June 1, 2009 for Oxycondone; June 2, 2009 for Methadone; June 5, 2009 for Oxycontin; and June 18, 2009 for Oxycontin."

20. On June 19, 2009, Board staff contacted Respondent at General Practice Clinic. Respondent admitted to Board staff that he was working at the clinic. Board staff notified Respondent that he was to appear at an informal interview on June 22, 2009 at 2:00 p.m. to discuss his prescription violations.

21. On June 22, 2009, Board staff obtained a pharmacy survey from the Pharmacy Board Database indicating that Respondent wrote over 350 prescriptions from May 8, 2009 to June 19, 2009, while the Consent Agreement for Practice Limitation was in effect, including for pain medications such as Oxycodone, Methadone, and Oxycontin.

22. Respondent did not appear at the scheduled investigational interview on June 22, 2009, due to a scheduling conflict with his attorney.

23. Board staff contacted Respondent again at General Practice Clinic, where he was treating patients. When Board staff reminded Respondent that he should not be working due to his practice restriction, Respondent replied that he would never have signed any document preventing him from practicing medicine.

24. At the hearing, Respondent testified that he never intended to sign a document restricting his medical practice.

25. Respondent violated the Consent Agreement for Practice Limitation by practicing medicine while the practice limitation was in effect.

26. The Board initiated Case No. MD-09-0528A pursuant to the Consent Agreement for Practice Limitation in Case No. MD-07-0237A.

27. By letter dated April 21, 2009, Lorraine Brown, a compliance officer for the Board, informed Respondent that an investigation of Case MD-07-0237A had been opened regarding his charting. Ms. Brown advised Respondent that Board staff would be conducting a random chart review to determine Respondent's compliance.

28. Marilyn Hart, M.D., a Board outside medical consultant, performed a chart review of four of Respondent's patient charts. Dr. Hart is a board-certified family practitioner.

29. Upon completion of her chart review, Dr. Hart issued a Medical Consultant Report, which contained the following Summary:

> I have reviewed 4 charts of Dr. Teague. It appears that there is a consistent lack of adequate history, past history including prior drs. records as well as adequate documentation addressing the pts various problems at visits. There is no assessment tool for pain med mgt and it appears by the charts there is inadequate follow through on multiple issues. I can not [*sic*] comment on how long he worked or took breaks. His notes were signed by another dr in his office.

30. The standard of care requires a physician to address patients' various problems during their visits, which include laboratory studies, providing assessment tools for pain medication management, and to follow up on multiple issues.

31. Respondent deviated from the standard of care because he did not note information of previous treating providers in the patients' records. He did not address the patients' various problems during their visits, including ordering laboratory studies. Respondent did not follow up on multiple issues.

32. There was a potential for medication addiction, abuse and/or overdose, toxicity or possible drug interaction for the four patients. However, Dr. Hart credibly testified that there was no documentation of actual harm to those patients.

33. Pursuant to A.R.S. § 32-1401(2), a physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify

the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Based upon Dr. Hart's chart review of the four patients, Respondent's records were inadequate because he did not document information from previous treating physician, he did not document addressing the patients' various problems, and there was a lack of adequate patient history, evaluation, and physical examination in the patients' records.

Case No. MD-08-1469A

34. The Board initiated Case No. MD-08-1469A after receiving a complaint dated December 5, 2008 from the son of patient K.C., who was a patient of Respondent.

35. The complaint alleged the following:

> Dr. Teague has prescribed the following drugs to my Mother on the following dates: 8/9/08 Vicoden 90 pills, 10/1/08 Lortab 7.5 mg. 90 pills, 10/1/08 Oxycontin 80 mg. 60 pills, 10/30/08 Remeron 32 mg. 30 pills, 10/30/08 Soma 350 mg. 120 pills, 11/10/08 Oxycontin 40 mg. 60 pills, 11/17/08 Soma 350 mg. 54 pills, 11/17/08 Oxycontin 80 mg. 60 pills, 11/19/08 Soma 350 mg. 56 pills, 11/19/08 Soma 350 mg. 56 pills, 11/30/08 Soma 350 mg. 120 pills. My Mother is now addicted to these drugs. Dr. Teague has prescribed 740 addictive pills to my Mother and has contributed to my Mother's addiction and two "near death" overdoses.

36. By letter dated December 16, 2008, the Board's case manager, Vicki Johansen, informed Respondent that the Board had opened an investigation due to the complaint received. Ms. Johansen requested that Respondent file a written response to the Board on or before December 31, 2008. Respondent failed to meet that deadline date.

37. By letter dated February 5, 2009, Respondent informed the Board that he refuted the allegations contained in the complaint.

38. Carol Peairs, M.D., an outside medical consultant for the Board, conducted an investigation of the complaint in this case. Dr. Peairs is board-certified in anesthesiology with a sub-specialty in pain management. She is chief of pain medicine at the local Veterans Administration.

39. Dr. Peairs issued a Medical Consultant Report dated April 20, 2009, which outlined her findings.

40. K.C. was identified as a 54-year old woman with a history of degenerative disc disease.

41. Dr. Peairs' report describes the following standard of care:

> Medical records should provide adequate information for another physician to assume care of the patient. Medical records should contain rationale for and response to medications prescribed. The medications prescribed should be readily discernible from the medical record.

42. Dr. Peairs opined that Respondent deviated from the above standard of care as follows: "The medical records fail to document the ongoing monthly prescribing of #90 Phenobarbital, #120 Soma, #150 Klonopin, #Remeron or the high dose Seroquel (600 mg daily for ten months)."

43. Dr. Peairs described the following standard of care:

> Medications should be prescribed rationally for the intended purpose. Counseling and appropriate warnings should be given as indicated for the medications prescribed.
>
> All patients taking Seroquel should be fully advised of the risks and signs of tardive dyskinesa (TD) to avoid unnecessary suffering that could occur and to identify early side effect precursors while TD may still be reversible. The risk of suffering TD becomes greater the longer Seroquel treatment continues, and the physician should monitor for side effects in an ongoing fashion.
>
> A general practitioner should refrain from prescribing for conditions of a nature and severity that are far beyond his/her scope of practice.

44. Dr. Peairs opined that Respondent deviated from the above standard of care as follows:

> Seroquel was documented as introduced at a dose of 200 mg tid for sleep, and discontinued the same month due to lack of efficacy for sleep. Seroquel 600 mg daily divided throughout the day is not rational for the off-label and controversial use of Seroquel for insomnia (usually a single dose of 25 to 100 mg at bedtime) and the dose is extraordinarily high for the off-label and controversial use for anxiety. The medical records indicate that Seroquel was

> discontinued within two weeks, and do not indicate that in fact, the licensee continued to prescribe Seroquel 600 mg daily in an ongoing fashion for ten months.
>
> The dosages of Seroquel are very high, and much higher than one would expect for off label treatment of insomnia (purpose as indicated in the medical record). Likewise, tid dosing is not rational for treatment of insomnia. These dosages are consistent with treatment of bipolar disorder or schizophrenia. Such treatment would be beyond the scope of a general practitioner.
>
> There is no documentation of counseling given to the patient regarding the multiple potential risks of high dose Seroquel, including early warning signs of tardive dyskinesia. There is no documentation that the licensee monitored the patient for side effects of Seroquel.

45. Dr. Peairs noted the there was no evidence of actual harm to K.C. She further noted that there was no evidence to support the complaint's allegation that K.C. had two near fatal overdoses.

46. Dr. Peairs did opine that K.C. was exposed to the following potential harm: TD, dependence, abuse, overdose, and that a physician assuming care of her "would not be able to discern the ongoing prescribing of controlled substances by the licensee."

47. Dr. Peairs' report contains the following Consultant's Summary:

> KC is a 54 year old woman with MRI documented severe degenerative lumbar spine disease. She had already undergone surgical consultation, injections, chiropractics and physical therapy at the time she established care with the licensee's associate in August 2007. An opioid treating agreement was signed at the first visit.
>
> She was seen at intervals no greater than one month for chronic back pain, by either the licensee or his associate. She was seen additionally for hypothyroidism, depression, insomnia, insurance examination and acute rib fracture. The licensee's associate introduced Oxycontin for chronic pain. This was renewed five times in less than three months by the licensee (8/27/08, 9/25/08, 10/1/08, 11/10/08, and 11/17/08), including two prescriptions for twice the initial dose and two early refills (one to replace allegedly stolen medications).

> The licensee's medical records are extremely sparse, and most if not all of the ongoing prescriptions for Klonopin, Seroquel, Phenobarbital, Remeron and Soma cannot be discerned from the office notes. It was necessary to review subpoenaed pharmacy surveys from Walgreens and CVS to identify the prescribed medications. Therefore, these prescriptions are not readily identifiable to a physician assuming care.
>
> Seroquel was introduced and continued at an irrationally high dose divided throughout the day. If this was prescribed off-label for insomnia, the dose and dosing intervals was [*sic*] irrational; If this was prescribed for treatment of bipolar disorder or schizophrenia (approved uses) then the licensee (a general practitioner) was prescribing for problems far outside his scope of practice.
>
> Of the sixteen office visits with the licensee, only three notes (two of the first three office visits, and the last office visit) were cosigned by his associate, Dr. Arnold DO. The significance of this, if any, is deferred to SIRC.

48. Dr. Peairs testimony at the hearing was consistent with her report.

Evaluations Performed of Respondent

49. On May 15, 2007 and May 23, 2007, Phillip D. Lett, Ph.D., performed a neuropsychological evaluation of Respondent pursuant to a Board order.

50. After completing the neuropsychological evaluation, Dr. Lett authored a written Neuropsychological Evaluation, which set forth his findings for the following categories: Referral Question; Basis of Evaluation; Background; Behavioral Observations and Mental Status; Review of Records; and Conclusions and Recommendations.

51. Dr. Lett found that Respondent exhibited mild cognitive processing inefficiency and stated that the measured inefficiencies may be age-related, in part. Respondent expressed concern that he has Attention Deficit Hyperactivity Disorder; therefore, Dr. Lett recommended that Respondent undergo a medical evaluation and then a psychiatric consultation. Dr. Lett further stated that Respondent should be able to function safely if he undergoes the consultations and practices in a structured setting with organized support staff.

52. On August 11, 2007, Respondent presented to Mark L. Rubin, M.D. for a psychiatric evaluation.

53. Dr. Rubin is a psychiatrist who is board-certified in psychiatry and child and adolescent psychiatry.

54. After performing his psychiatric evaluation of Respondent, Dr. Rubin authored a written Physician's Psychiatric Evaluation report, which set forth his findings in the following categories: Current Situation; Previous Psychiatric History; Current Living Arrangements; Education; Legal Problems; Birth and Developmental History; Family Psychiatric History; Past Medical History; Allergies; Medications; Social History; Mental Examination; Assessment; Diagnosis; and Recommendations.

55. Dr. Rubin discussed with Respondent Respondent's concerns of Attention Deficit Disorder but did not make that diagnosis. Dr. Rubin noted cognitive decline and recommended that Respondent not see patients directly or, if he does so, not see them more than four hours per day, five days per week. Dr. Rubin also recommended that Respondent's work be reviewed by a partner or collaborating allopathic physician prior to the end of each day. Dr. Rubin recommended that this process continue until Respondent's retirement.

56. The Board had directed Respondent to pay for the psychiatric evaluation. Dr. Rubin testified that he normally charges patients $1,500.00 for a psychiatric evaluation. As a personal courtesy, Dr. Rubin charged Respondent $750.00 for the psychiatric evaluation. Respondent's check to Dr. Rubin was returned for insufficient funds. Respondent testified that he had paid Dr. Rubin. Dr. Rubin has forgiven the debt. Dr. Rubin completed his Physician's Psychiatric Evaluation prior to the check being returned to him for insufficient funds. Respondent is not charged with failing to pay Dr. Rubin. However, Respondent's response to Dr. Rubin's testimony about this issue raises concerns about Respondent's credibility.

57. Dr. Rubin testified consistently with his written Physician's Psychiatric Evaluation report.

Discussion

58. In view of the foregoing Findings of Fact, the Administrative Law Judge finds that allowing Respondent to continue practicing allopathic medicine would threaten the public's health, safety, and welfare.

59. Respondent is found to be not capable of being regulated by the Board. Respondent's violation of prior Board Orders, especially the recent Consent Agreement for Practice Limitation, supports this Finding of Fact.[1]

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case.
2. Pursuant to A.R.S. § 41-1092.07(G) (1) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is preponderance of the evidence. A.A.C. R2-19-119(A).
3. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27) (e) ("[f]ailing or refusing to maintain adequate records on a patient").
4. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27) (q) ([a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public").
5. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27) (r) ([v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter").
6. The conduct and circumstances described in the above Findings of Fact support a conclusion that Respondent is mentally or physically unable safely to engage in the practice of medicine pursuant to A.R.S. § 32-1451(M).
7. The conduct and circumstances described in the above Findings of Fact support a conclusion that the public health, safety or welfare imperatively required emergency action, pursuant to A.R.S. § 32-1451(D), when the Board summarily suspended Respondent's license to practice allopathic medicine after it discovered that Respondent continued to practice medicine after voluntarily entering into the

[1] Another example of Respondent's inability to be regulated is his failure to appear at the pre-hearing conference scheduled in this administrative proceeding.

Consent Agreement for Practice Limitation, which prohibited him from practicing medicine.

ORDER

Based on the foregoing the Board orders that on the effective date of the Order entered in this matter, Dr. Robert C. Teague's License No. 3925 is revoked.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 7th day of October, 2009.

THE ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 7 day of October, 2009 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

COPY OF THE FOREGOING FILED this 7 day of October, 2009 with:

Cliff J. Vanell, Director
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Executed copy of the foregoing mailed by U.S. Mail this 7 day of October, 2009 to:

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